Important Advances in Clinical Medicine

Epitomes of Progress—General and Family Practice

The Scientific Board of the California Medical Association presents the following inventory of items of progress in General and Family Practice. Each item, in the judgment of a panel of knowledgeable physicians, has recently become reasonably firmly established, both as to scientific fact and important clinical significance. The items are presented in simple epitome and an authoritative reference, both to the item itself and to the subject as a whole, is generally given for those who may be unfamiliar with a particular item. The purpose is to assist the busy practitioner, student, research worker or scholar to stay abreast of these items of progress in General and Family Practice which have recently achieved a substantial degree of authoritative acceptance, whether in his own field of special interest or another.

The items of progress listed below were selected by the Advisory Panel to the Section on General and Family Practice of the California Medical Association and the summaries were prepared under its direction.

Reprint requests to: Division of Scientific and Educational Activities, 693 Sutter Street, San Francisco, Ca. 94102

Treatment of Streptococcal Pharyngitis by Clinical Criteria

CLINICAL CRITERIA CAN BE USED to diagnose and treat pharyngitis without a culture if the effects of age and causative agent are considered.

Studies have shown that accuracy of clinical diagnosis averages 75 to 80 percent. However, within this average, there are areas of extremely high accuracy. A study to be published shows that accuracy is 97 percent when a clinical diagnosis of viral pharyngitis is made in an adult. Accuracy fell to 41 percent when a clinical diagnosis of streptococcal pharyngitis was made in a child. Unfortunately the studies which attack clinical diagnosis are usually by pediatricians.

Adenitis and exudate are the two most important criteria in making a clinical diagnosis. Temperature and injection are less important. Viral pharyngitis is diagnosed if all of these findings are absent or if temperature alone is present along with typical influenza symptoms. Streptococcal pharyngitis should be diagnosed only in the presence of (1) marked exudate (without signs of mononucleosis), (2) marked erythema, (3) a combination of adenitis, temperature, and moderate injection or exudate.

Between the viral and the streptococcal categories are patients with unexplained temperature, adenitis, minimal injection, or minimal exudate along with their pharyngitis. These should be placed in a questionable category and cultures taken before treatment.

For adults with a clinical diagnosis of viral pharyngitis, cultures should not be done. The incidence of rheumatic fever will be only 1 in 8,000 if clinical diagnosis rather than laboratory diagnosis is used. Cultures would be an inefficient use of health dollars.

Children diagnosed clinically as having viral pharyngitis should have cultures even though accuracy is a relatively high 86 percent, since their risk of rheumatic fever is much greater.

It is generally agreed that patients given a clinical diagnosis of streptococcal pharyngitis should be treated before culture results are available to

minimize the possibility of rheumatic fever. Clinical accuracy in the previously mentioned series was approximately 70 percent for adults and 40 percent for children. This is high enough to justify immediate therapy without culture for adults, provided it is oral and the danger of anaphylaxis is avoided.

Penicillin injections in children are not justified because of the inaccuracy of clinical diagnosis and the danger of delayed sensitivity in later life. However, the greater incidence of rheumatic fever in children suggests that oral therapy should be started pending culture. Studies have shown that eradication of steptococcal infection is excellent by oral therapy if proper instruction is given to the patient.

By following these criteria, over 70 percent of cultures can be eliminated. A majority of clinicians already treat on the basis of clinical judgment. By adhering to standard criteria and taking cultures in pediatric pharyngitis and questionable cases in adults, the cost of medical care can be reduced without danger.

ROGER A. FORSYTH, MD

REFERENCES

Forsyth RA: The rationale of treatment of pharyngitis on the basis of clinical diagnosis. To be published

Colcher IS, Bass JW: Pencillin treatment of streptoccal pharyngitis. JAMA 222:657, 1972

Pain in Viral vs. Bacterial Pharyngitis

IT IS GENERALLY ACCEPTED that streptococcal pharyngitis cannot be diagnosed from clinical findings alone without significant error.

Since the two commonest bacterial organisms responsible for acute pharyngitis are the group A streptococcus and C. diphtheriae, and since the latter can usually be excluded on clinical grounds, the physician must ask, when he makes the diagnosis of pharyngitis, whether it is caused by group A streptococcus or by a virus. The diagnosis of pharyngitis is often made on the basis of the complaint of "sore throat" without definite signs of redness, exudate or ulceration of the pharynx.

In any general practice the problem of differentiating viral from bacterial pharyngitis is a daily problem. Much has been made of the "beefy" pharyngitis so often typical of streptococcal sore throat, but another aid to differentiation can be made from the history.

As a general rule, pharyngeal pain which occurs primarily or is most severe at bedtime and on arising may help to differentiate viral from bacterial sore throat. The latter tends to be more or less constant throughout the patient's waking hours. With a history of persistent daytime pharyngeal soreness, it is desirable to obtain a throat culture, even though the pharynx is not inflamed. In these patients an occasional unexpected hemolytic streptococcus infection will be discovered.

S. CLARKE SMITH, MD

REFERENCES

Rapkin RH, Eppley ML: The recognition of streptococcal pharyngitis. Community Health 10-12:706-710, Dec 1971

Schultz I, Fundelfiner B, Rosenbaum M: Comparison of clinical manifestations of respiratory illness due to Asian strain influenza, adenovirus, and unknown cause. J Lab Clin Med 55:497, 1960

Office Dilatation and Curettage

ALTHOUGH METHODS of endometrial sampling have been present for approximately fifty years, there has been relatively little acceptance of any but the traditional dilatation and curettage. Adequate diagnostic D & C can be done in the office with the Poyas cannula. The equipment needed consists of three cervical dilators and matching cannula curettes, tubing with a specimen trap, and low pressure suction pump commonly used in most offices. The stainless steel cannula curettes are 12 inches long, with a 4, 5, or 6 mm outside diameter. The tips are straightened to produce the effect of a sharp curette and the shaft is slightly curved to allow free rotation and contact with the uterine wall.

The procedure is carried out much as the traditional D & C, with a careful bimanual examination beforehand to determine uterine size, shape and position. Visualization can be improved with a weighted speculum. The cervix is then grasped with a single tooth tenaculum and cleansed. Depth is determined with the introduction of the 4 mm dilator and most cervical canals can then be dilated to the large (6 mm) diameter. If the dilatation is uncomfortable for the patient, a paracervical block using 5 cc of 1 percent lidocaine (Xylocaine®) at the 4 and 8 o'clock positions will afford adequate relief. Thorough curettage can then be carried out, and the removed tissue aspirated into the trap. The tubing can be cleared at the end of the procedure with a small amount of formalin and the specimen sent to the laboratory. Even very scanty specimens will be adequate for pathological diagnosis if a "cell block" is asked for.

Where this suction procedure has been done and the conventional method and/or hysterectomy